**Psychotherapy**

Introduction: Eric M. Plakun, MD

# Bias Toward Psychodynamic Therapy: Framing the Problem and Working Toward a Solution

Allan Abbass MD, FRCPC, Patrick Luyten PhD, Christiane Steinert, PhD and Falk Leichsenring, DSc

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ABBASS: Centre for Emotions and Health, Dalhousie University, Canada; LUYTEN: University College London, United Kingdon, and University of Leuven, Belgium; STEINERT: University of Giessen, Germany, and Medical School, Berlin, Germany; LEICHSENRING: University of Giessen, Germany; PLAKUN: Associate Medical Director, Director of Biopsychosocial Advocacy, Austen Riggs Center, Stockbridge, MA, and Leader, American Psychiatric Association Psychotherapy Caucus, Arlington, VA

Please send correspondence to: Allan Abbass, Professor and Director, Centre for Emotions and Health, Dalhousie University, Rm 7507, 5909 Veterans Memorial Lane, Halifax, Nova Scotia, Canada (email: allan.abbass@dal.ca).

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**Running head: PSYCHOTHERAPY**

**Abstract**

Although psychodynamic therapy (PDT) is an evidence-based intervention for a broad spectrum of psychiatric conditions, there is often notable bias in the way PDT is depicted both in the popular media and in the scientific literature. This has contributed to a negative view of PDT, which hampers both patient access to this treatment and researcher access to funding for further research on PDT. The adverse effects of these distortions and biases are detrimental not only to PDT but also to the overall field of psychotherapy, raising questions about its credibility. Here we summarize current evidence for PDT, describe existing biases, and formulate a set of recommendations to foster a more balanced perspective on PDT.

KEY WORDS: psychotherapy, psychodynamic therapy, psychotherapy research

# Introduction to Guest Column

**Eric M. Plakun, MD**
**Psychotherapy Section Editor**

This column had its origins on the 161st birthday of Sigmund Freud on May 6, 2017, while I was listening to Garrison Keillor's *Writer's Almanac* piece for that day on National Public Radio. Keillor cited Freud's birthday in his piece, but after describing Freud's seminal work on dreams and his focus on the centrality of unconscious factors in determining human behavior, Keillor concluded his comments by stating that science had by now largely debunked Freud's theories. I was dumbstruck by this offhanded and completely inaccurate statement from a usually knowledgeable radio commentator. It reminded me of other examples I had come across of gross misinformation and bias with respect to psychoanalysis and psychodynamic therapy. For example, among general psychiatrist colleagues with whom I work in the American Psychiatric Association (APA) Assembly, no one would ever utter a joke about a minority group, but periodic jokes poking fun at psychoanalysts still turn up now and then. About a month later, I saw the PsychiatryOnline version of a paper by Christiane Steinert[1] and her group that was in press in the American Journal of Psychiatry, reporting "equivalence" of psychodynamic therapy with other forms of therapy. I knew then that I wanted to do a column on the problem of implicit bias toward psychodynamic therapy and psychoanalysis.

As I hope has been clear in all of these columns to date, they are about psychotherapy in general and do not favor one school of psychotherapy over another. We have too much work to do together to persuade a field that tends toward biological

reductionism in its thinking about etiology and treatment of disorders for this column or this columnist to join the proverbial “circular firing squad,” in which psychotherapists from competing schools argue with one another about who has the best therapy or the best research. This implicit bias, as the guest columnists show, goes beyond needless competition between schools and it reflects poorly on the credibility of psychotherapy as a form of treatment and on the quality of psychotherapy research of all kinds. It also runs counter to the recommendation from the Institute of Medicine's *Report on Psychosocial Interventions in Mental Health and Substance Use Disorders* that we increase efforts to identify shared elements across forms of therapy that are associated with change.[2] We cannot allow implicit bias to lead us to ignore science. I am delighted and grateful that these 4 leading psychodynamic therapy researchers agreed to take on the task of describing these biases, citing evidence that unmasks them, and making recommendations to move forward.

# Bias Toward Psychodynamic Therapy: Framing the Problem and Working Toward a Solution

Guest Columnists: Allan Abbass, Patrick Luyten, Christiane Steinert and Falk Leichsenring

Psychodynamic therapy (PDT) as a family of treatments is an evidence-based intervention for a broad spectrum of psychiatric conditions.[3–5] PDT has been shown to be as effective as other psychosocial interventions, including the family of treatments known under the rubric of cognitive behavioral therapy (CBT).[6] Despite this, PDT continues to receive what appears to be biased treatment in treatment guidelines, reviews, and related publications, and in media that inform the public's perception and ultimately patient access to this effective treatment modality.

## EVIDENCE FOR PDT

The efficacy and effectiveness of PDT for common mental disorders have been supported by several systematic reviews and meta-analyses. A Cochrane review investigating the efficacy of brief (under 40 sessions) PDT for common mental disorders, for instance, found that PDT outperformed wait-list, treatment as usual, and minimal contact comparisons at both short- and long- term follow-up.[3] Longer-term psychodynamic therapy has been found to be effective in complex mental disorders, including in patients with personality disorders, chronic mental disorders, or multiple mental disorders.[7–9] In complex mental disorders, the longer term versions of PDT appear more effective than short-term therapies. According to the Chambless and Hollon criteria[10] for empirically supported therapies, PDT is "efficacious" or "probably efficacious" in most common mental disorders.[11] In addition, meta-analyses have found no statistically significant differences in outcome between individual PDT and other forms of individual psychotherapy in patients with anxiety or depressive disorders,[12,13] and in patients with more

complex mental disorders.[14,15] A recent meta-analysis specifically designed to test for equivalence in outcomes found PDT to be as efficacious as treatments with established efficacy, such as CBT, across various mental disorders.[6]

## BIAS IN THE DEPICTION OF PDT

Despite the evidence for PDT, biases in the depiction of PDT and of PDT research remain, and threaten to reduce the further development of and thereby limit patient access to PDT. Many of these biases appear to be due to 5 general biases that have been documented in scientific research, most notably researcher allegiance and the application of double standards.[16,17]

### Bias 1. Distorted Depictions of Psychodynamic Therapy as a Science

Many textbooks of clinical psychology and basic psychology describe psychodynamic approaches, at best, as historically important in psychology's development, but as currently out-dated and obsolete. At worst, psychodynamic approaches are depicted as unscientific or even pseudoscientific.[18] What these depictions have in common is that they are typically based on caricatured versions of early psychoanalytic assumptions (example: repressed libido as the only dynamic force) while ignoring contemporary psychodynamic approaches and the considerable empirical evidence for these views that has emerged over the past few decades.[19] Unfortunately, this distorted image of current PDT has penetrated popular media and university curricula, damaging the perspectives of both mental health professionals and prospective patients.[20,21]

### Bias 2. Exclusion or Distortion of Evidence Related to PDT in Treatment Guidelines

Several treatment guidelines exclude or downgrade PDT, often under the guise of the purportedly smaller evidence base for PDT, even though a higher number studies does not in and of itself provide evidence for superiority. For instance, in the treatment of anxiety disorders, a recent meta-analysis[22] showed that more than 80% of 121 trials of CBT focusing on anxiety disorders used wait-list control groups; only 17% of studies were of high quality. But even when there are a large number of trials available for PDT of a specific condition, this does not necessarily lead to comparable and unbiased presentation of PDT. For instance, the recently published Canadian Guidelines for the Management of Adults with Major Depressive Disorder (Canadian Network for Mood & Anxiety Disorders or CANMAT)[23] placed brief PDT as a second- rather than a first-line treatment for depression, despite citing a 54 study meta-analysis showing large persistent effects and equal effects between individual PDT and other individual treatment modalities.[12] Furthermore, even when this inconsistency was pointed out, the guideline committee did not revise its conclusions and also neglected to consider the outcomes of large studies showing non-inferiority of PDT to CBT.[24] A similar struggle occurred recently in Sweden where the National Board of Health and Welfare recruited a skewed mix of professionals to develop treatment guidance: the opinions of the few PDT professionals were outvoted leading to guidance undervaluing PDT.[25]

Research bodies such as the U.S. National Institute of Mental Health similarly appear to perpetuate distorted or biased information about PDT.[26] For example, under the categories of anxiety disorders, borderline personality disorder, depression, and eating disorders, there is no mention of PDT as a valid treatment option. In a separate section describing psychotherapies,[27] there is a notable absence of discussion of psychodynamic as well as other contributions to psychotherapy. The focus in these descriptions is on cognitive and behavioral processes, while

the language used is typical of CBT, which could mislead the public to believe that the only relevant psychotherapy approach is CBT.

As another example, a recent comprehensive review of psychosocial interventions in anxiety disorders[28] completely downplayed the evidence for PDT in the treatment of these disorders, even when confronted with evidence from meta-analyses showing similar effects of PDT compared with other treatments in these conditions.[13.29].

**Bias 3. Exclusion of Psychodynamic Researchers From Funding and Guidelines Committees**

Although there are considerable regional differences, psychodynamic researchers are often excluded from committees responsible for developing treatment guidelines or for reviewing research and making decisions about research funding. For example, the CANMAT group mentioned above initially included PDT researchers, but they were subsequently removed from the group without explanation, leaving PDT data to be interpreted by researchers with allegiances to different schools of therapy.[30]

**Bias 4. Use of Neutered Versions of "Psychodynamic Therapy" in Randomized Clinical Trials: The "Straw Man" Bias**

A particularly pernicious problem has been the use of neutered versions of "psychodynamic therapy" in some trials. For example, in a study of posttraumatic stress disorder, therapists delivering the PDT model were restricted from speaking about the trauma itself, a withholding that patients must have found both unusual and frustrating.[31] The use of diluted PDT

methods as "straw man" controls that are intended to fail was described for the first time more than three decades ago by Smith et al[32]: "A comparison condition might be set up as a kind of straw man over which the favored therapy would prevail. The comparison condition (often an ´insight therapy´) would be treated with fairly obvious disdain, and would not be given as much opportunity for success" (p. 119). Surprisingly, this bias still exists, as has been amply documented in a number of recent reviews.[16,33.34] This bias among others affects the replicability, validity, and credibility of all psychotherapy research.[35]

**Bias 5. Biased Study Selection in Meta-Analyses**

The selection of studies in meta-analyses is frequently biased against PDT. It has been easy to demonstrate that, in some meta-analyses, typically including researchers with allegiance to a single and different form of therapy, study selection is performed in ways that exclude valid PDT studies, on the one hand, and that include flawed PDT studies, on the other. A meta-analysis by Marcus et al.,[36] for example, which purportedly claimed to investigate the effectiveness of CBT versus other treatment modalities (including PDT) included only three questionable studies of PDT, but omitted a large number of RCTs comparing PDT with other bona fide psychotherapies. Baardseth et al.[37] showed that several studies of bona fide psychotherapies, including PDT, were excluded in a similar way for unclear reasons in another meta-analysis purporting to find a consistent advantage for a particular family of treatments.[38] Table 1 lists the varieties of bias toward PDT.

## A WAY FORWARD

If this problem of bias is not addressed, we not only risk that patients will be denied access to effective treatments, but we miss the opportunity for dialogue and collaboration that could enhance the credibility of scientific psychosocial interventions— at present, the credibility of research in psychology is severely questioned.[39] We propose the following steps to help move the field in a more sensible and healthy direction. These recommendations are in accordance with Chambers´ manifesto [39] for reforming the culture of scientific practice.

Clearly, for the public to have balanced information, researchers and clinicians who are knowledgeable about the current literature on PDT should be routinely included in committees charged with guideline development, funding decisions, webpage publications, and organizations furthering psychotherapy as a collective treatment approach. Furthermore, researcher allegiances and other conflicts of interest should be collected and consistently disclosed, so readers have a context for the materials.

Given the shared objective of all psychotherapy proponents to increase the effectiveness and scope of psychosocial interventions, collaborative research should be done using what has been called “adversarial collaboration” to further develop psychotherapy as a collective. Those conducting meta-analyses and review groups should consult with researchers from other models beyond the allegiance of the core group to yield a richer synthesis and contextualization of findings. Finally, shared research should continue on key therapy elements versus overall therapy models toward identifying which interventions work best for whom. This may be especially relevant in relation to therapeutic factors such as emotional experience/exposure[40] or change in person-environment exchanges [41] as presumed key ingredients across treatment modalities. Table 2 lists recommendations for corrective action.

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